MECHANICS OF T-NEX FINANCING

Overview

- Goals of T-Nex Finance
- What's Changing—Healthcare
- What's Changing—Admin
- MCSC Cost Calculation—Example
- Revised Finance under T-Nex

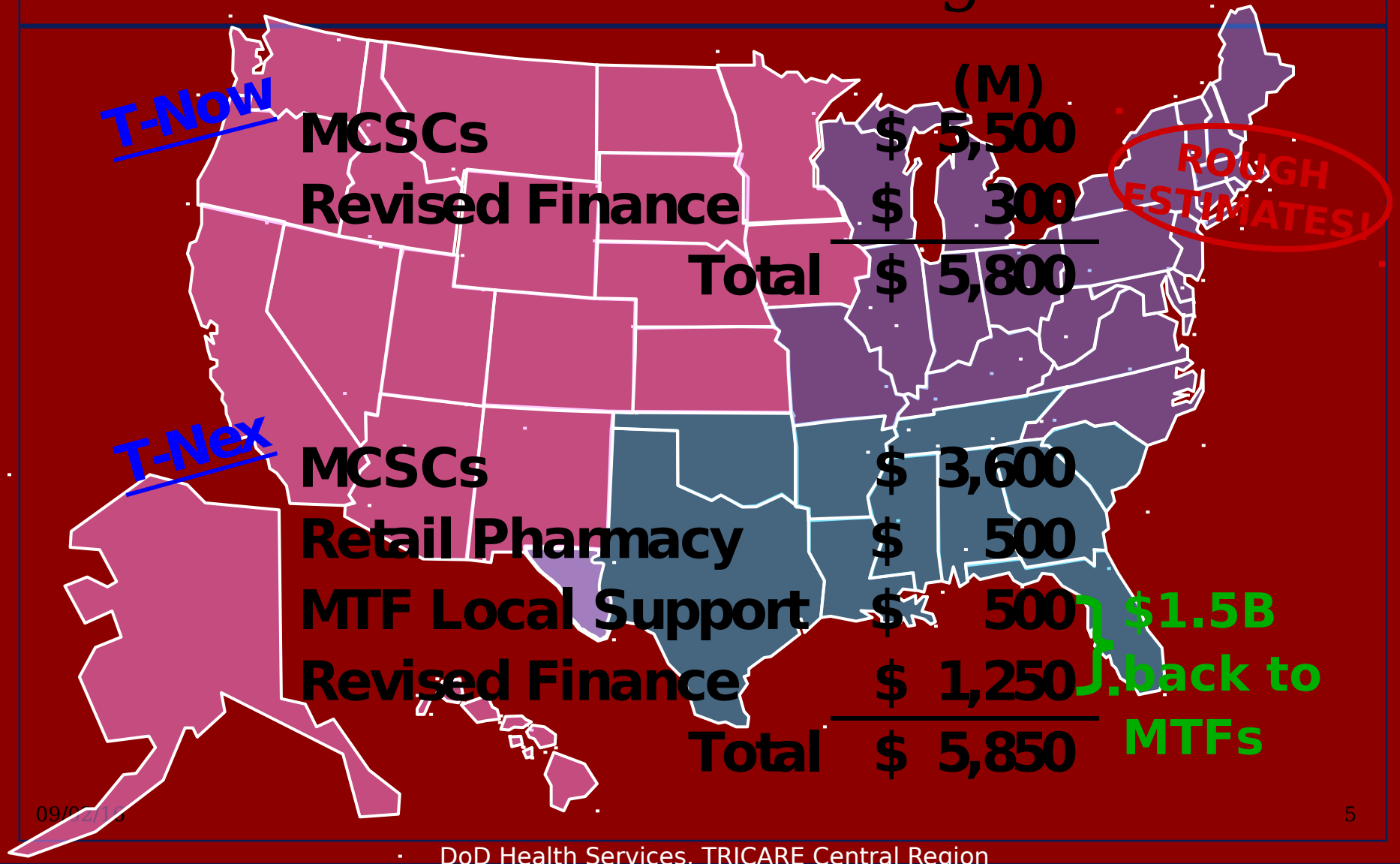
Why Change?

- Unpredictable Budgets
  - Lengthy close-out of Option Periods… 18 months
- Complicated Contracts
- Reliance on MHS Data Quality
- Change Orders Problematic
- Complicated Bidding
- Perverse Incentives

T-Nex Objectives

- More Predictable Budgets
  - Improve ability to forecast budgetary requirements
  - Close out prior year costs faster
  - Avoid REAs, simplify change-orders
- Contain Costs
  - Motivate cost control by MCSCs
  - Provides incentives and support to maximize capacity (optimization)
- Improve Contract Management
  - Enhance competition
  - Easier bidding, evaluation and implementation
  - Incentivize customer service
- Simplify Financing Mechanisms
  - Eliminates complicated BPAs
  - Reduces disputes regarding data and risk

Where's The Money Moving ??



T-Now

	(M)
MCSCs	$ 5,500
Revised Finance	$ 300
Total	$ 5,800

ROUGH ESTIMATES!

T-Nex

MCSCs	$ 3,600
Retail Pharmacy	$ 500
MTF Local Support	$ 500
Revised Finance	$ 1,250
Total	$ 5,850

$1.5B back to MTFs

Health Care/Admin Contract Financial-- Overview

Healthcare Costs

Contractor and Government will share risk for healthcare costs

- Risk sharing approximates level of underwriting in current contracts

MTFs will be funded for the expected level of private sector costs for their enrollees

- Revised Financing
- Supplemental care

Administrative Costs

All other services provided by the MCSS contractor (e.g. claims processing, beneficiary svcs, mgt etc)

What's Changing – Healthcare

Claims Costs: PMPM ➔ Pass-through/Cash

Bids: 5 years ➔ Year 1 only

Annual Targets:

BPAs ➔ Annual Neg/Trend

Risk Sharing Corridors:

Varied ➔ Straight 80/20

Rev Finance: 3 regions ➔ Nationwide

What's Changing – Admin

Claims Processing: Cost reimb ➔ Fixed Price/Claim

Disease Mgmt: ➔ Cost reimbursed

Non-Claims Services: Cost reimb ➔ PMPM basis

Medical Management: Healthcare ➔ Admin

Performance Incentives: No ➔ Yes

- Govt creates Award Pool, up to 10%, for incentives focusing on beneficiary satisfaction, RD satisfaction, provider satisfaction

~$200M Per Region

Example: How Contract Works - Year 1

Govt provides historical claims data for region and projections of TRICARE eligibles

Offeror bids:

- Target healthcare costs for Year 1
- Fee (profit) for each contract year
- Admin price for each contract year

After Year 1

- Govt compares actual claims in Year 1 to target
  - Calculation based on all purchased care costs
    - Including Revised Financing
  - Deviations from target shared 80/20
    - Max profit 10% of target cost
    - Minimum profit -4% of target cost
- Award fee determination for admin services made periodically during period of performance

Example of Profit Calculation

If Actual Healthcare Cost is	Government Pays Contractor ($ millions)	Net Contractor Gain/Loss
$800M (Target)	$800 + $25 = $825	$25M
$750M	$750 + $25 + .2(800-750) = $785	$35M
$700M	$700 + $25 + .2(800-700) = $745	$45M
$825M	$825 + $25 + .2(800-825) = $845	$20M
$950M	$950 + $25 + .2(800-950) = $945	-$5M

Example of Annual Negotiation for Year 2

- For Year 2, target cost negotiated at Month 7 of Year 1
- Target cost determined by considering incurred costs and cost estimates for next period
- A variety of tools to be used to help govt estimate cost (indices, formulas etc)
- Contractor and govt negotiate, agree to target for next period
- If no agreement ➔ National Trend Factor Formula

National Trend Factor Formula

Sets target cost retrospectively at conclusion of contract year

Target cost equals actual cost from prior option multiplied by national TRICARE trend

Example: For Year 3 of contract, target cost equals actual costs in Year 2, multiplied by national trend from Year 2 to Year 3

Example: National Trend Factor Formula

Regional Cost	National Cost			Target Cost in
(FY04)	FY04	FY05	% Trend	Region for FY05
$725M	$3,500M	$3,850M	10%	$725 x 1.1 = $798M

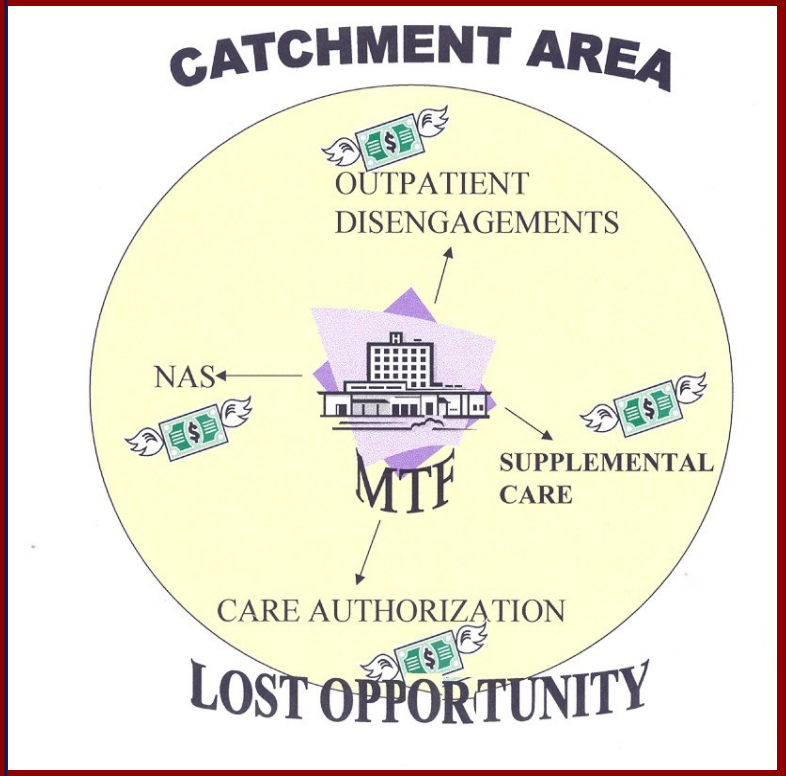
Summary

T-Nex Model Should:

- Provide strong customer service incentives
- Provide stronger incentives for contractor to use MTFs (no MTF BPA, no “O” factor)
- Provide cost control incentives for MTFs due to revised financing and risk sharing
- Provide cost control incentives for contractors (risk sharing)
- Improve budget predictability (simpler and quicker adjustments)
- Reduce complexity
- Eliminate most healthcare change order negotiations

T-Nex
Revised Financing

Revised Financing Strategy



Strong MTF Commander involvement

- Optimizing the MTF
- Maximizing care to MTF enrollees and Non-MTF enrollees in market area

Strong MTF referral screening program

- Managing the appointment template
- Managing referrals for purchased care

Data Analysis

- Understanding what is ‘leaking out’
- Business initiatives
- Resource Sharing

Revised Financing Principles

- Financing for MTF Prime Enrollees
  - MTFs will have funding to manage their Prime enrollee health care purchased downtown
    - Includes both AD and CHAMPUS enrollees
      - Revised Financing
      - Supplemental Care
    - Excludes Retail and Mail Order pharmacy
- Goals
  - Provide incentives for MTFs to maximize their capacity
  - Provide management and cost control incentives for managing MTF enrollee healthcare
  - Improve the 'real-time' cost impacts of management decisions

Revised Finance

Why Bother?

What's In Your Budget

Invoicing Issue/Funds Flow

Current Status

Revised Finance…Why Bother?

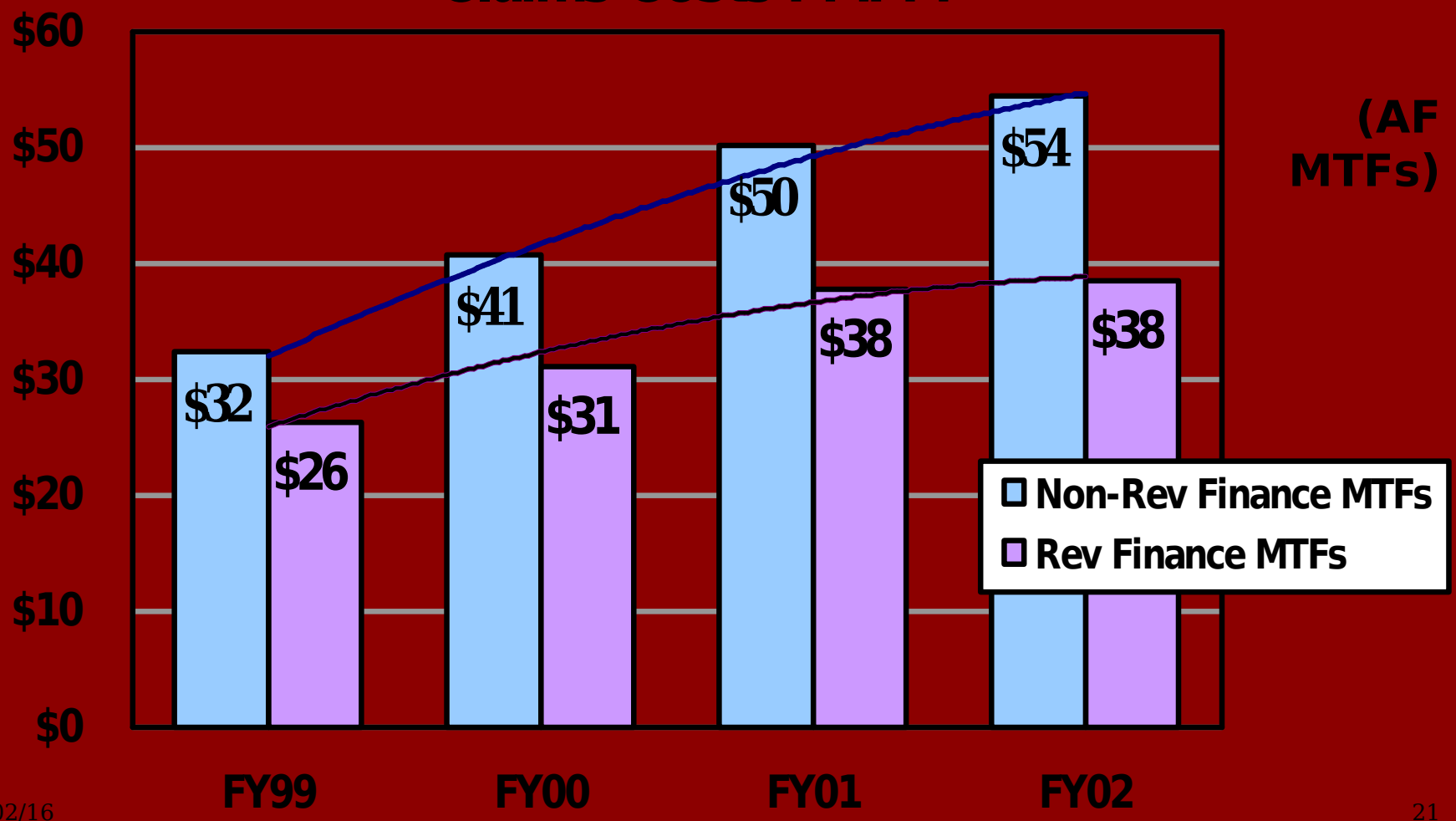
Growth in Centralized PSC Programs

- Managed Care Support 30%
- Supplemental Care 19%
- Overseas Healthcare 23%
- Active Duty Dental248%

Growth in Decentralized PSC Programs

- Revised Finance 10%
  - Enrollment growth 7%
- MTF Supplemental Care 9%

Revised Finance…Why Bother? (cont)



What's In Your Budget

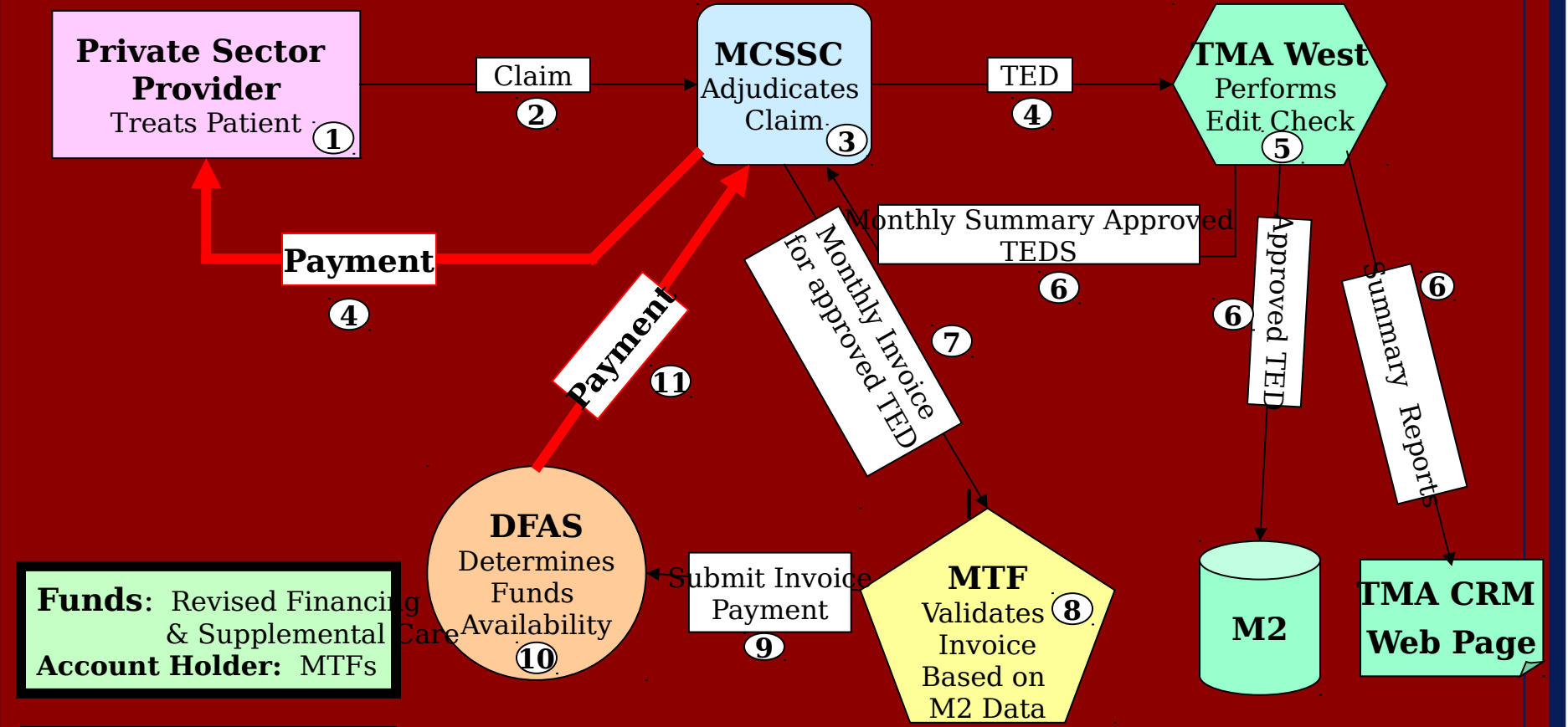
- Purchased Care Funds for MTF Enrollees
  - Includes AD Enrollees (AD non-enrollees paid centrally)
  - Excludes Pharmacy
- AFMS initial allocation = FY02 claims costs, inflated
  - Disputes on Inflation Rates and Enrollment Adjustment
- Catastrophic Claims (>$100K)
  - MAJCOMs to manage
- Projected MTF Budgets Available on TMA Purchased Care Website
  - https://199.211.84.37/Purchased_Care/

Invoicing Issue

- Apr 2003 ASD(HA) expressed concern over invoicing process
  - Too Complicated
  - Incurs $12-20M/Annual Float Charge
  - Re-do Plan
- TMA-RA tasked to look at streamlining process while maintaining the Services objectives
  - Align financial responsibility with authority; MTF have funds
  - MTFs accountable to manage spectrum of health care for their enrolled population
  - Tighten linkage between performance and financial impacts
- Worked with Service RMs to develop simplified process

Original Claims Payment Process

(Contractors reimbursed in 30 business days or greater



Revised Financing Payments

MTF provides obligation authority to TMA-W via reimbursable MIPR
- Avoids cross disbursement

TMA-W processes and pays TEDS
- TMA-W determines thru DMIS-ID which MTF to charge
- Claims batched on a daily/weekly/monthly basis
- Sent electronically to DFAS via IPAC

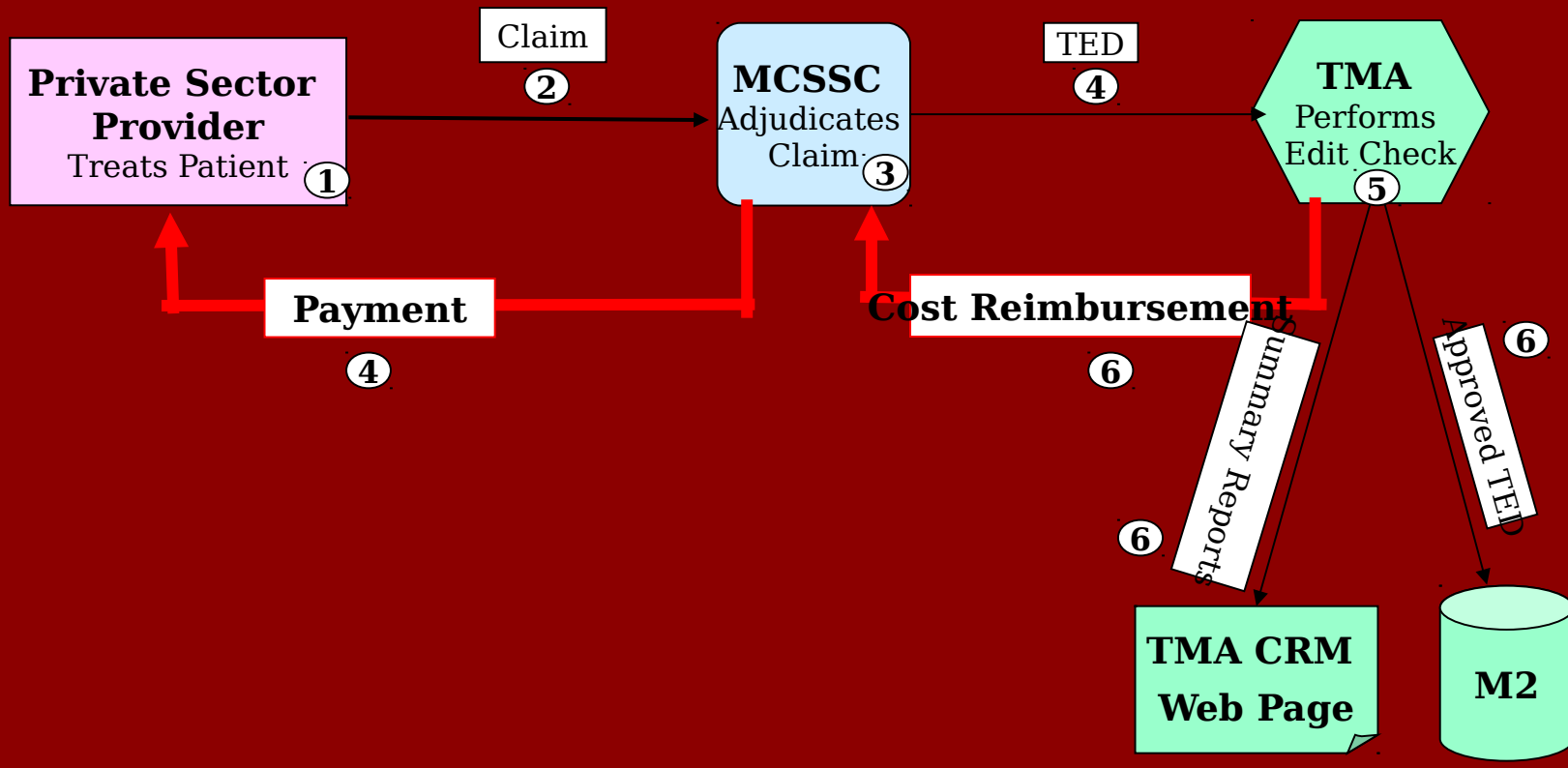
DFAS posts the disbursement transaction via IPAC & liquidates the obligation recorded by the MTF

Financial Effect on the MTF "New Payment Plan"

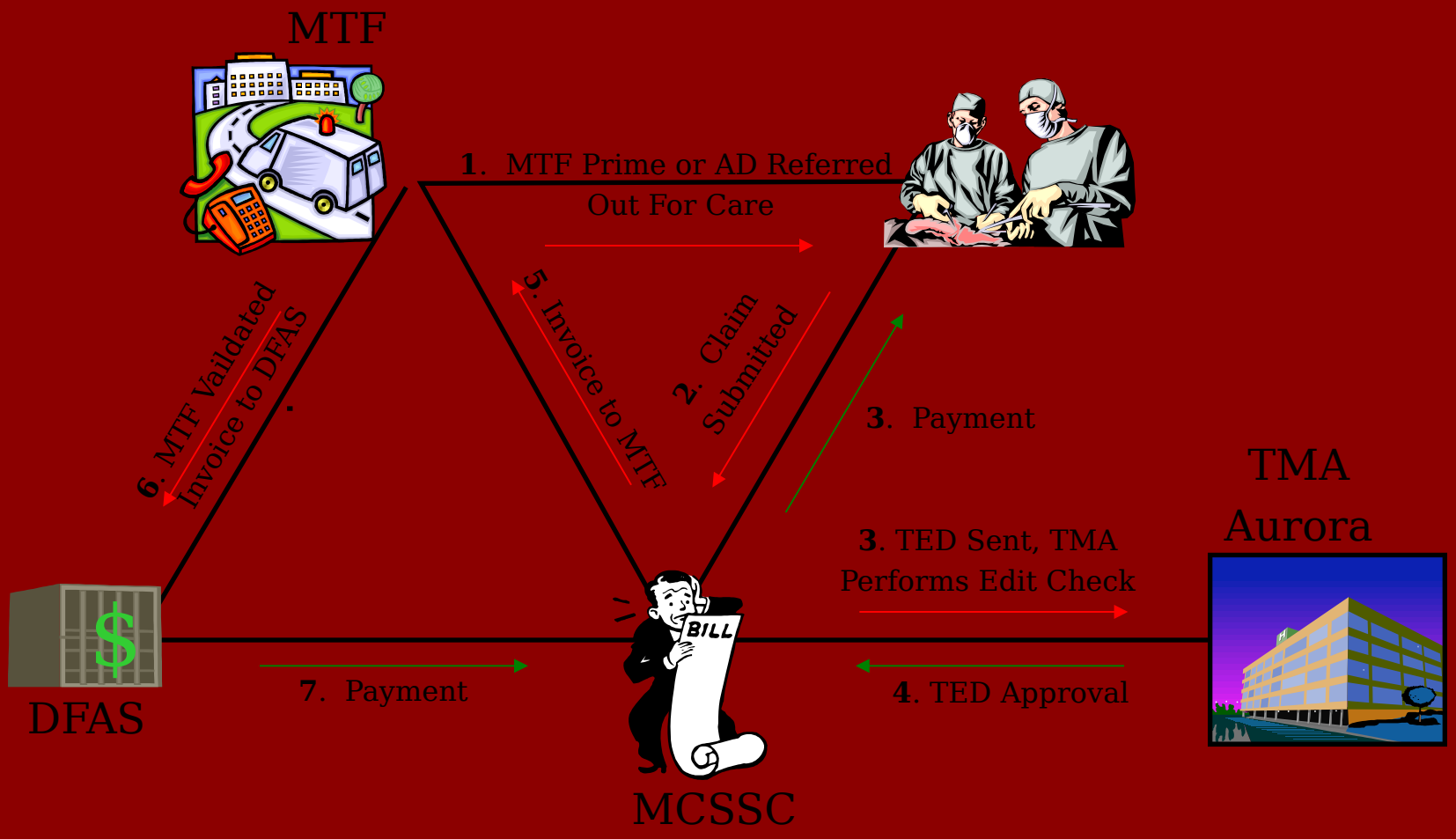
- TMA will pay claims centrally
  - MTFs will provide authority to TMA to pay enrollee care claims
  - All claims paid in two to three business days
    - Contractor uses the same process for all claims
  - Uses new E-commerce techniques
  - MTF commanders will remain financially responsible for enrollee care
  - Accommodates MTF business plans, data flow, and reporting as planned

Simplified Claims Payment Process

(Contractors reimbursed in 2-3 business days)



MTF Enrollee Claims



Financial Effect on the MTF Reporting Process

- Daily transactions to be posted on TMA-W's PSC website
  - Daily transaction balances will be available
  - TEDS details will be available for data analysis on M2
  - Similar to e-banking
  - https://199.211.84.37/Purchased_Care/Index.cfm
- Reports will be created for MTF "quick" viewing
- All levels within MHS available to customize reports to fit their own specific needs

Next Steps

- Working with DFAS/Services to finalize reimbursement processes/business rules
  - 18-19 Nov 03 workgroup meeting to iron out details and processes
  - Disseminate business rules so folks in the field will be educated on the process
- Contract modification language completed
  - Need to issue modification to contractors
- Decision on how best to handle new appropriation language
  - Concern over transfer of funds from MTFs to pay for contractor-provided medical care. To limit such transfers within the DHP, language designating PSC under TRICARE program as a separate sub-appropriation within the DHP. Any transfer of funds in/out of the PSC sub-appropriation will require the Department of Defense to follow prior approval reprogramming procedures

What You Should Be Concerning Yourself With

Your Referral Processes

Case Management / Utilization Management

Make-Buy Decision Capability

Tracking PSC Deployment Costs

Questions ??